Robin A. Sykes, MD, PA

FORMERLY

JUPITER PLASTIC SURGERY CENTER

304 Tequesta Drive, #300, Tequesta, FL 33469

FINANCIAL POLICY

ALL NEW PATIENTS MUST SIGN THIS FORM BEFORE BEING SEEN BY THE DOCTOR.

Thank you for choosing Jupiter Plastic Surgery Center for your plastic surgery needs. We are committed to giving you quality time and treatment. We now ask you to read and sign our financial policy so that there is no confusion regarding fees in our office and our release of information policy regarding medical history and photographs.

Patients are ultimately responsible for charges arising from the services we render. For your convenience we accept Visa, MasterCard, and Discover. New patients having a cosmetic consultation will be charged a one-time fee of $75. If you have cosmetic surgery, this fee will be applied toward your surgery cost.

Dr. Sykes is a Medicare provider. She is not a "participating provider" with any other insurance plan. If you have a PPO plan and have a medically necessary procedure, you will be asked to pay for services when they are performed. We will provide you with a receipt that includes the procedure and diagnosis that you may submit to your insurance company on your own.

In order to access insurance benefits for eligible services, your signature on this release is required. Under HIPAA guidelines, it is also necessary for patients to acknowledge the medical use and confidentiality of the medical record and medical photographs taken by this office.

I hereby authorize and empower Robin A. Sykes, M.D. to:

- Make, compile, and maintain a full, complete medical record including, but not limited to, completion of the personal history and physical examination.
- Take required photographs, X-rays, and measurements.
- Do everything necessary, proper, incidental, and implied for carrying out of the purpose and object of the services herein mentioned.
- Use at her sole discretion all material whatever nature arising herefrom for literary, scientific, medical, or educational purposes without remuneration. Your photos may be shown, for educational purposes, to other patients unless you request otherwise.
- Permission to submit a claim to an insurance company for purpose of collection and to bill patient for any applicable amount.

_____ _____

Patient Signature (or legal representative) Witness

If patient is a minor, complete the following:

Patient is a minor, _____ years of age, and I, the undersigned, am the parent or legal guardian of the patient and do hereby consent for the patient.

_____ _____

Patient Name Signature of Parent or Legal Guardian